French definition of dyspepsia from the last century: "the remorse of a guilty stomach."[3] A modern definition suggested by an international working party is less concise and no more precise.[4]

ROBERT METCALF
GILES R YOUNGS

Chester Royal Infirmary,
Chester CH1 2AZ

1 Jones R, Lydeard S. Prevalence of symptoms of dyspepsia in the community. *Br Med J* 1989;**298**:30-2. (7 January.)
2 Kingham JGC, Fairclough PD, Dawson AM. What is indigestion? *J R Soc Med* 1983;**76**:183-6.
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4 Working Party. Management of dyspepsia. *Lancet* 1988;i:576-8.

The white paper, junior doctors' hours, and emergency services

SIR,—The hours worked by junior hospital doctors have once again received well deserved publicity. Now the publication of the white paper on the NHS provides a good opportunity to seek a solution to a complicated issue which has several aspects.

Firstly, this is not just a matter of hours on duty. Junior doctors are certainly essential contributors to emergency care, but they are also trainees who require supervised experience in this vital subject. Additionally, they all have to study, attend courses, sit examinations, and seek further appointments. To stressful on call duty are added demanding off duty activities.

Secondly, the character of emergency work has changed. In several vascular and gastrointestinal emergencies, for example, the best option may now be for the patient to have a major definitive operation immediately. Skill and experience are needed both to select patients for and to perform such operations.[1,2]

Thirdly, the training requirements and the care of patients both indicate the need for more participation of consultants in emergency care. I recall, however, the sharp reaction to the Short report of 1982, which was thought to entail consultants sleeping in hospital when on call. This understandable response from doctors already doing a full day's work inhibited the consideration of reasonable ways of making consultant skill available out of hours. With more consultants it should be possible to work out fair on call rotas. Sharing of responsibility would ease the burden on junior staff and improve their training. There is a good case for making whole time consultant appointments more attractive. Living in should not be necessary if the many overseas graduates who wish to spend a period of training in the NHS are fully integrated into United Kingdom registrar rotation schemes.[3]

Finally, the encouragement given in the white paper to developing private practice needs to be considered. This may ease pressure on NHS beds, but any increase in private work means that consultants spend more time away from NHS hospitals. The 100 extra consultants, distributed among various specialties in many district hospitals, may have to devote considerable energy to compensating for these absences.

Now is an opportune time for the BMA to take the lead in securing a comprehensive examination of emergency services in NHS hospitals.

PETER F JONES

Cults,
Aberdeen AB1 9HR

1 Jenkins AMcL, Ruckley CV, Nolan B. Ruptured abdominal aortic aneurysm. *Br J Surg* 1986;**73**:395-8.
2 Koruth NM, Krukowski ZH, Youngson GG, *et al.* Intraoperative colonic irrigation in the management of left-sided large bowel emergencies. *Br J Surg* 1985;**72**:708-11.
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Lack of sleep in junior doctors

SIR,—Your correspondence columns might give the impression that it is only junior doctors in hospital who suffer from lack of sleep. It should not be forgotten that senior hospital doctors (and many others) are sometimes on duty from Friday morning to Monday night and beyond. In the acute services particularly this commonly leads to night work as well as day work.

Acute medicine cannot be regulated to occur during social hours, and no one taking up these various specialties at present should expect a regular and normal pattern of sleep every day of the week. That is not to say that the unsocial and excessive hours should not be reduced by better local organisation and management.

Perhaps the white paper *Working for Patients*, with its tightening of consultant contracts, will eventually lead to a shift system for junior and senior doctors alike so that all will enjoy adequate sleep and time for their managerial roles as well as time (but less) for clinically related work.

J M MANNERS

General Hospital, Southampton

Junior doctors' pay: a block to reducing hours

SIR,—A junior doctor working 9 am to 5 pm on weekdays plus a 1:3 rota for evenings and weekends works 84 hours a week. A bill currently before the House of Lords recommends that the maximum number of hours worked should be 72 hours. To achieve this on a basic 1:3 rota requires that one day (8 hours) and one afternoon (3 hours) should be taken as time off.

Under the present pay structure basic minimum salary is calculated on the standard unit of medical time (UMT)—10 a week usually worked Monday to Friday. Additional hours worked are paid as class A UMTs, which are calculated by a complicated formula from the basic salary. The ways in which junior doctors' salaries are made up are shown in the table. These are based on the first year in a given grade and a 1:3 rota, giving 13 class A UMTs. At present the practice with regard to taking one afternoon off a week varies among authorities. In some authorities the afternoon off is "unofficial," while in others a single class A UMT is deducted from pay in view of the afternoon off. This practice does not adhere to the letter of the present arrangements.

Although it is possible to allow an unofficial afternoon off, it would, I suspect, not be acceptable to allow an unofficial one and a half days off. The effect of reducing hours by taking one and a half days off duty during the week is also included in the table. It would cause financial loss of a magnitude that would be unreasonable and certainly unacceptable to the juniors. In addition, since the value of a class A UMT is calculated from the basic salary derived from standard UMTs, pay would further be reduced.

On my (general medical) firm, after discussions with my juniors, the consensus was that it would be possible to organise the week so that all juniors had one and a half days off. I am quite willing for this to happen. With the present pay structure, however, it is quite impracticable to do this without all the juniors concerned suffering a huge loss in salary. The pay structure must be changed before any progress can be made. It would seem reasonable to base the minimum salary on a 72 hour week, and any hours worked beyond that should be paid at a higher rate—for example, 1·25 standard UMTs for the first 10 hours, 1·5 for the next 10 hours, and 2 for any hours worked beyond 20. A structure along these lines would provide a strong disincentive to management to continue to employ already fatigued and overworked juniors.

K G E BROWN

District Diabetes Centre, Farnborough Hospital,
Orpington, Kent

Grade	Basic salary, first scale point, 40 h week	Additional payment for 1:3 rota (13 class A UMTs)	Standard UMT	Annual loss if three standard UMTs are taken off
House officer	9 520	4705	18·31	2856
Senior house officer	11 870	5868	22·83	3561
Registrar	13 470	5956	25·90	4040
Senior registrar	15 510	6050	29·83	4653

History of coeliac disease

SIR,—All historians are cautious about memory and personal reminscence. Dr Bernard J Smits[1] recounts comments attributed to me at a postgraduate meeting by Dr William Paveley in his article on the history of coeliac disease.[2] He goes on to describe conversations with other participants in that outstanding work in The Netherlands that so clearly showed the harmful effect of gluten in coeliac disease. I don't know if he ever talked with Dr Dicke about his work. I did—as a young and unknown gastroenterologist to whom he extended the hospitality of his home even though already afflicted with the illness from which he subsequently died. Dr Dicke was a truly remarkable man, with a vision and breadth of view that marked him out from his fellows. He was quite clear in his conversation with me that it was a young mother's statement that her coeliac child's rash improved if she removed bread from the diet that first alerted his interest. And that was when he was a paediatrician in the Hague in 1936. But then, of course, you only have my word for that, and as Francis Bacon put it: "Truth is the daughter of time and not of authority."

CHRISTOPHER BOOTH

London NW1 4RP

1 Smits BJ. History of coeliac disease. *Br Med J* 1989;**298**:387. (11 February.)
2 Paveley WF. From Aretaeus to Crosby: a history of coeliac disease. *Br Med J* 1988;**297**:1646-9.

Wanted: poster friendly conferences

SIR,—Dr W F Whimster's excellent editorial contains only one tiny but crucial defect[1]: not only should conference organisers inform participants of the height and width of the display area but they should tell them which is which. I belong to a learned society that routinely offers a space measuring 1·2×0·9 m (4×3 feet) but, equally routinely, declines to state the orientation of this space. Anyone who has been caught by an unexpected change in the orientation between successive meetings will understand the frustration caused when expected to fit a poster 1·2 m wide and 0·9 m high, prepared after hours of creative agonies, into a space 0·9 m wide and 1·2 m high. In such circumstances there is a strong temptation to pin the organiser to the background, irrespective of the suitability of its colour and material. As pathologists we have the technology....

EMYR W BENBOW

Department of Pathology, University of Manchester,
Manchester M13 9PT

1 Whimster WF. Wanted: reader friendly posters. *Br Med J* 1989;**298**:274 (4 February.)